

# Patient Intake Form



Please answer the following questions carefully and accurately. The answers to these questions will help us to understand your pain problem and design the best treatment program for you.

You may feel concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential. No outsider is permitted to see your case record without your written permission, unless we are required to do so by law (e.g., Worker's Compensation Claim).

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

### Characteristics of Pain (Chief Complaint):

What is the reason for your visit at Reno Tahoe Pain Associates:

- \_\_\_\_ New Onset Symptom Evaluation
- \_\_\_\_ Follow-up Evaluation
- \_\_\_\_ Ongoing Management
- \_\_\_\_ Other Visit Reason (Describe): \_\_\_\_\_

### History of Present Illness:

Please describe the location(s) of your pain:  
\_\_\_\_\_  
\_\_\_\_\_

### Pain Rating:

#### Current Pain Level

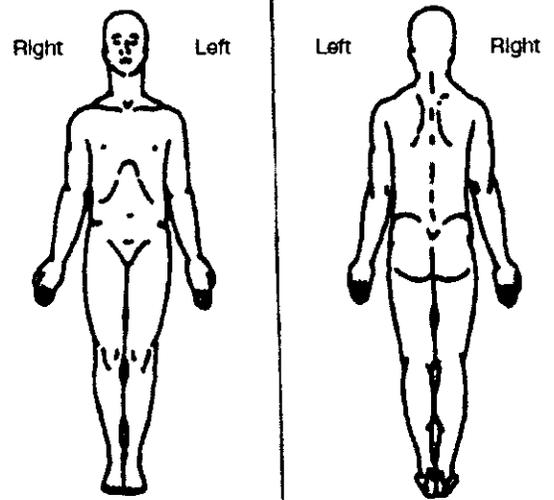
0 1 2 3 4 5 6 7 8 9 10  
☺ \_\_\_\_\_ ☹

#### Minimum Pain Level

0 1 2 3 4 5 6 7 8 9 10  
☺ \_\_\_\_\_ ☹

#### Maximum Pain Level

0 1 2 3 4 5 6 7 8 9 10  
☺ \_\_\_\_\_ ☹



**Have you done any imaging (CT, MRI, X-Ray, DXA, PET) on the areas that hurt?** Yes / No

**If yes, what facility?:** \_\_\_\_\_

### Pain Duration:

How long have you had your current pain problem(s)?

\_\_\_\_ Weeks    \_\_\_\_ Months    \_\_\_\_ Years

**Onset of Pain (Cause):**

How did your current pain start?

- Injury at work
- Injury NOT at work
- Treatment caused (e.g., radiation, surgery, etc.)
- Motor Vehicle Accident
- Illness
- Undetermined

**Progression of Pain:**

- Acute (quick/ severe)
- Gradual (slow)
- Sudden (unexpected)
- Variable (intermittent)

**Associated Symptoms:**

- "Pins and needles"
- Numbness
- Tingling
- Weakness

**Pain Quality:**

How would you describe your pain?

- Burning
- Cutting
- Sharp
- Throbbing
- Cramping
- Dull, Aching
- Pressure
- Shooting
- Other

**Frequency/ Timing of Pain:**

How often do you have your pain? (CHECK ONE)

- Constantly (100% of the time)
- Nearly constantly (60% - 95% of the time)
- Intermittently (30% - 60% of the time)
- Occasionally (less than 30% of the time)

In general, during the past month, when has your pain been worse? (CHECK ONE)

- Morning
- Afternoon
- Evening
- Night
- No typical pattern

**Relieving and Aggravating Factors:**

How do the following affect your pain?  
(CHECK ONE FOR EACH ITEM)

	Decrease in pain	No Change	Increase in pain
Lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relaxation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing/ Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Activities and your pain:**

Place a checkmark next to the activities that you have avoided or limited during the past month, because of pain:

- Going to work
- Doing yardwork or shopping
- Socializing with friends and family
- Participating in recreation
- Having sexual relations
- Performing household chores
- Exercise
- Sitting
- Standing
- Walking

**Attempted Treatments:**

Treatment	Date (Approx.)	No Relief	Moderate Relief	Excellent Relief	Facility Name
<input type="checkbox"/> Bed Rest		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-----
<input type="checkbox"/> Traction		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Surgery		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Hypnosis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Acupuncture		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Nerve Block		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> TENS		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Physical Therapy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Exercise		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-----
<input type="checkbox"/> Heat		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-----
<input type="checkbox"/> Ice		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-----
<input type="checkbox"/> Biofeedback		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Psychotherapy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Chiropractic		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Effect on Sleep**

- No effect
- Pain makes it difficult to fall asleep
- Pain makes it difficult to stay asleep

**Effect on Bowel and Bladder**

**Control:**

- No effect
- Loss of bladder control
- Loss of bowel control

**Assisting Device:**

- Cane
- Walker
- Wheelchair
- Other: \_\_\_\_\_
- None

**PAST MEDICAL HISTORY:**

**Medical:**

Have you had any of the following health problems? (**CHECK ALL THAT APPLY**)

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Angina/ Chest pain | <input type="checkbox"/> Diabetes Type I     | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Diabetes Type II    | <input type="checkbox"/> Liver Disease  | <input type="checkbox"/> TIA             |
| <input type="checkbox"/> Asthma/ Wheezing   | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Peptic Ulcer   |  |
| <input type="checkbox"/> Bleeding Problem   | <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Reflux (GERD)  |  |
| <input type="checkbox"/> Chronic Cough      | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizure        |  |
| <input type="checkbox"/> COPD               | <input type="checkbox"/> High Blood Sugar    | <input type="checkbox"/> Stroke         |  |
| <input type="checkbox"/> Cancer (type):     |  | <input type="checkbox"/> Other:         |  |

**Implanted Electronic Devices:**

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**Surgical History:**

**General Family Illness:**

Please check any health problems that are known to run in your family:

Angina/ Chest pain	Diabetes or High Blood Sugar	Liver Disease	Seizure or Epilepsy
Arthritis	Bleeding Problem	Kidney Disease	TIA
Asthma/ Wheezing	Heart Attack	Peptic Ulcer	Stroke
Chronic Cough	High Blood Pressure	Reflux (GERD)	Thyroid Problem
Cancer (type):	Other:		
Unknown Family History			

**Social History:**

Smoker: \_\_\_\_ NO \_\_\_\_ FORMER \_\_\_\_ YES If yes, # of packs per day: \_\_\_\_  
Alcohol: \_\_\_\_ NO \_\_\_\_ FORMER \_\_\_\_ YES If yes, average # of drinks per day: \_\_\_\_  
History of drug addiction: \_\_\_\_ NO \_\_\_\_ YES  
Marital Status: \_\_\_\_  
Children: \_\_\_\_ NO \_\_\_\_ YES How many: \_\_\_\_  
Living/Home Status: Nursing Facility / Assisted Living / With Family / Self / Other: \_\_\_\_  
Education: \_\_\_\_  
Work Status: Disabled / Retired / Work Full time / Work Part Time / Other: \_\_\_\_  
Occupation: \_\_\_\_

**Review of Systems:**

Please check all the items you feel are applicable to you:

**GENERAL:**

- Fever
- Night sweats
- Chills
- Cold intolerance
- Fatigue
- Daytime somnolence
- Weight gain
- Weight loss
- Polydipsia

**RESPIRATORY:**

- Dyspnea
- Cough
- Cough Productive of Sputum
- Hemoptysis
- Wheezing

**CARDIOVASCULAR:**

- Chest pain
- Palpitations
- Dyspnea at rest
- Dyspnea with activity
- Orthopnea
- Paroxysmal
- Lower extremity edema
- Varicosities

**GASTROINTESTINAL**

- Abdominal pain
- Rectal pain
- Nausea
- Vomiting
- Vomiting blood
- Constipation
- Decreased frequency of bowel movement
- Diarrhea

**HEMATOLOGIC/ LYMPHATIC:**

- Easy bruising
- Difficulty stopping blood flow
- Lymph node enlargement
- Lymph node tenderness

**MUSCULOSKELETAL:**

- Muscle pain
- Back pain
- Tender points
- Muscle cramps
- Muscle weakness
- Decreased muscle strength
- Limb paralysis
- Difficulty walking

**NEUROLOGICAL:**

- Headaches
- Vertigo
- Lightheadedness
- Fainting
- Blackouts
- Numbness
- Tingling
- Tremor
- Lack of coordination
- Weakness
- Difficulty speaking
- Memory loss
- Difficulty concentrating

**PSYCHIATRIC:**

- Change in mood
- Depression
- Anxiety
- Nervousness
- Sleep disturbance
- Suicidal ideation
- Hopelessness
- Worthlessness
- Delusions
- Hallucinations

**Medications:**

Please list **ALL** medication(s) that you are currently taking

Please see attached list

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Please list any pain medication you have tried in the past:

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**Drug Allergies:**

Please list any medications you are allergic too:

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**YES**, I am allergic to dye put onto my body ("X-ray dye")

# LEG PAIN QUESTIONNAIRE

Venous Insufficiency is a serious circulatory problem in which the leg veins cannot pump enough blood back to your heart. It affects 2.5 million Americans, most over the age of 40. Symptoms of venous insufficiency include varicose veins, skin problems, leg and ankle swelling, tight calves, legs that feel heavy, tired, restless, or achy. Factors that can increase the risk of venous insufficiency include pregnancy, obesity, smoking, standing, or sitting for long periods of time, and not getting enough exercise. Answers to these questions will determine if you are at risk for venous insufficiency and if a vascular exam will help us better assess your leg pain.

**Do you suffer from:**

<input type="checkbox"/> Leg Pain	Right / Left	<input type="checkbox"/> Tired / Heavy Legs	Right / Left	<input type="checkbox"/> Leg Aching	Right / Left
<input type="checkbox"/> Leg Itching	Right / Left	<input type="checkbox"/> Burning/Stinging	Right / Left	<input type="checkbox"/> Throbbing	Right / Left
<input type="checkbox"/> Leg Cramps	Right / Left	<input type="checkbox"/> Skin Color Changes	Right / Left	<input type="checkbox"/> Blood Clots (DVT)	Right / Left
<input type="checkbox"/> Leg Swelling	Right / Left	<input type="checkbox"/> Traumatic Bleeding	Right / Left	<input type="checkbox"/> Leg Ulcers	Right / Left
<input type="checkbox"/> Blue lines on Legs	Right / Left	<input type="checkbox"/> Rope-Like Veins	Right / Left	<input type="checkbox"/> Knots	Right / Left
<input type="checkbox"/> Spider Veins	Right / Left	<input type="checkbox"/> Varicose Veins	Right / Left	<input type="checkbox"/> Restless Leg(s)	Right / Left

**Swelling:**

If you push on your foot, ankle, or leg for 10 seconds and release, does your fingerprint leave a dimple? Yes / No

How long have you experienced the above symptoms? \_\_\_\_\_

Have these symptoms affected your work/activities?

None / Minimally / Mildly / Moderately / Severely / Unable to work

**Are your symptoms worse with:**

prolonged standing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
prolonged sitting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
exercise or walking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
at the end of the day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Menses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

**Have you had any of these medical problems?**

<input type="checkbox"/> Clotting Disorder	<input type="checkbox"/> Need for blood thinner medication
<input type="checkbox"/> Leg trauma	<input type="checkbox"/> Prolonged immobility for any reason
<input type="checkbox"/> Obesity	<input type="checkbox"/> Pulmonary Embolus
<input type="checkbox"/> Major Trauma	<input type="checkbox"/> Venous-related ulcers
<input type="checkbox"/> Thrombocytopenia	

**Check off any that provide relief for your leg pain**

<input type="checkbox"/> Elevation	<input type="checkbox"/> Rest	<input type="checkbox"/> Compression Stockings: Duration of use: _____ None / Intermittent / Most Days / Full Compliance Strength of stockings: 8-15 mmHg / 20-30 mmHg / 30-40 mmHg
<input type="checkbox"/> Aleve, Motrin, Tylenol	<input type="checkbox"/> Massage	
<input type="checkbox"/> Support Hose	<input type="checkbox"/> Walking	

Have you seen a physician for this problem?  Yes  No

If yes, did you receive treatment?  Yes  No

What was the treatment? \_\_\_\_\_

## Extraneous Paperwork Policy

I understand that Reno Tahoe Pain Associates does not complete any documentation for Long Term Disability initiation or recertification. Nor do they complete paperwork for long-term DMV Disabled Placards. Reno Tahoe Pain Associates will only do 6-month certifications and recertification of DMV Disabled Placards paperwork, at provider discretion. Short-term disability and FMLA paperwork are filled out at the providers discretion.

Please be aware that the type of care that Reno Tahoe Pain Associates provides does not require extensive periods of recovery. Therefore, we cannot medically back extended periods of absences.

There is a charge for any extraneous paperwork to be filled out and signed. However, there is no charge if paperwork is brought to an appointment at the time of the appointment. If paperwork is brought before or after an appointment, there is a flat fee charge of \$25.00. Anything beyond 5 pages incurs a charge of \$5 per page. We have 5 business days to complete paperwork.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

## Acknowledgement of Privacy Practices and Policies

### Treatment Authorization:

I hereby authorize Reno Tahoe Pain Associates to render healthcare to me during my visit.

### Privacy Notice:

I have been given the option to review Reno Tahoe Pain Associates "Notice of Privacy Practices" that explains how my personal health information will be used. I am also aware that I may request a copy of the "Notice of Privacy Practices" at any time.

### Medical Records:

I am aware that I may request a copy of my medical records at any time, with written consent. In addition, I understand there may be a fee associated with my request and that without a release on file stating otherwise, my records can only be picked up by me or mailed to the address on file. Please note, third-party requests are also the patient's financial responsibility after 60 days of non-payment.

**By signing below, I acknowledge Reno Tahoe Pain Associates Privacy Practices and Policies and adhere to them.**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Print Your Name

\_\_\_\_\_  
Signature

## Patient Care and Medication Agreement

**\*\*Please initial by each bullet point and sign at the bottom of this agreement.\*\***

**As the patient of Reno Tahoe Pain Associates, I agree to the following:**

- \_\_\_\_\_ 1. I will provide complete information about my illness/problem, medications and health habits to enable proper evaluation and treatment.
- \_\_\_\_\_ 2. I, and others who accompany me to my appointments or call on my behalf, will show respect to office personnel and other patients. Lack of such may lead to dismissal from the practice.
- \_\_\_\_\_ 3. I will check into my appointments 15 minutes before my appointment time and understand that if I arrive at my appointment time or later, my appointment may be rescheduled and a No-Show fee will be charged (\$25).
- \_\_\_\_\_ 4. It is my responsibility to keep up with my scheduled appointments.
- \_\_\_\_\_ 5. I will pay co-pays or bills in a timely manner and agree that failure to do so will result in dismissal from the practice.
- \_\_\_\_\_ 6. I consent to random drug screens if I take control II, III, and IV medications. I understand that if I do not comply, I will not be prescribed the controlled substance.
- \_\_\_\_\_ 7. I will use prescriptions or other medical devices prescribed according to directions. I will not take prescriptions or use medical devices differently without first talking to the doctor or other members of the treatment team.
- \_\_\_\_\_ 8. I will use only one pharmacy to get all of my control II, III, and IV medications, unless my pharmacy is unable to fill my prescription.
- \_\_\_\_\_ 9. I will bring my control II, III, and IV substances in their original bottles as directed by my provider. I understand I may be asked to bring my medications at any time to be counted to ensure my compliance with taking my medications as prescribed, and understand if I do not do so, I may be dismissed from the practice.
- \_\_\_\_\_ 10. I understand that refills will be made only during business hours Monday-Thursday, and that it is my responsibility to request refills early enough to allow at least two business days for medication refills to be called in for me, should they be approved.
- \_\_\_\_\_ 11. I will accept responsibility for my actions including misuse of drugs (whether illicit or prescription), tobacco, alcohol, or other activities, selling, diverting and sharing my medication. I understand that if I do, the provider will no longer prescribe controlled substances.

- \_\_\_\_\_ 12. If my medication is stolen. I am required to provide the police report. It is then at my providers discretion whether a new prescription is issued. I also understand that if the prescription is reissued, it is then at the pharmacist's discretion whether the medication is refilled or not.
- \_\_\_\_\_ 13. If my medication is damaged, it is at my providers discretion whether a new prescription is issued. I also understand that if the prescription is reissued, it is then at the pharmacist's discretion whether the medication is refilled or not.
- \_\_\_\_\_ 14. I will inform my provider of all other medicines that I take, and let them know right away if I have a prescription for a new medicine.
- \_\_\_\_\_ 15. I will follow the guidelines set for any limitations in work, activity, or diet.
- \_\_\_\_\_ 16. I will participate in all other types of recommended treatment including multimodal analgesia and comprehensive pain treatments (i.e. physical therapy, TENS unit, pain psychology, medical management, and interventional treatments). If I do not, my provider has the right to refuse increases to my control II, III, and IV medication regiment.
- \_\_\_\_\_ 17. I will complete the required psychological assessments bi-annually.
- \_\_\_\_\_ 18. If I am prescribed control II, III, and IV medication at Reno Tahoe Pain Associates, I will only receive the aforementioned from my treating provider at Reno Tahoe Pain Associates. If I receive control II, III, and IV medication from another provider outside of this practice without approval from my treating team at Reno Tahoe Pain Associates, my medication treatment will be discontinued.
- \_\_\_\_\_ 19. If I am prescribed control II, III, and IV medication at Reno Tahoe Pain Associates, I will not use Kratom/Mitragyna. Otherwise, my medication will be discontinued.
- \_\_\_\_\_ 20. I understand that if I refuse to consent to a drug screen at my first visit, that I will forfeit my right to being prescribed any pain medication in the future. Including following any surgical procedures.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Signature

## PSYCHOLOGICAL PAIN ASSESSMENT POLICY AND FINANCIAL DISCLOSURE

This notice is presented to explain the policy of Reno Tahoe Pain Associates regarding Narcotic Prescriptions and our psychological pain assessments.

Chronic pain is a complex condition that affects millions worldwide, impacting not only physical health but also mental and emotional well-being. It's often misunderstood and improperly managed, leading to significant challenges for both patients and healthcare providers.

Research increasingly shows that chronic pain is not solely a physical issue; it is deeply intertwined with psychological factors such as stress, anxiety, depression, trauma, and coping mechanisms. These psychological elements can exacerbate pain perception, hinder recovery, and impede the effectiveness of medical interventions.

By assessing psychological factors, our healthcare professionals can gain valuable insights into your overall well-being, identify underlying issues contributing to pain experiences, and tailor treatment plans accordingly. Thus, we integrate psychological assessments into the management of chronic pain to foster a more holistic and patient-centered approach.

Our office conducts this via diagnosticIQ questionnaires that are filled out by you every 6 months. This is something that is billed for by our office when it is reviewed by our providers and again after the discussion of the results. Regretfully, this may or may not be covered by your insurance. While a majority of insurance companies do in fact pay for this service, some do not. For this reason, we have an advanced beneficiary notice (ABN) that you will need to sign.

This notice simply states that you understand this screen may not be covered by your insurance, and in the event that it is not, you will be financially responsible for the fees incurred. We will do our best to work with you if your insurance does not pay for this service. Please remember, it is ultimately your responsibility to be aware of your insurance benefits.

Please remember that you may or may not receive medications from our facility and this may or may not be tested. This notification is given to prevent any confusion or misunderstanding in the future, and to ensure that all patients understand our commitment to providing the best care and service.

**By initialing below, you acknowledge our Psychological Pain Assessment, and adhere to the requirements of RTPA.**

\_\_\_\_\_ **Initials**

**Communication Authorization:**

Reno Tahoe Pain Associates has adopted a policy that requires our staff to obtain authorization from the patient to release and/or leave a detailed message for the patient. Secondary to the HIPPA guidelines we need to guard against violating any patient confidentiality and protect our staff.

If we do not have a signed consent on file we may only leave our name and phone number on an answering machine asking you to call back.

By completing the consent below you authorize us to release information or leave a detailed message on voicemail.

I hereby authorize Reno Tahoe Pain Associates to communicate with the following, regarding all aspects of my medical care and financial obligations:

A. I \_\_\_\_\_ (print name), give my consent to Reno Tahoe Pain Associates staff to release and/or leave messages regarding my care or lab results as necessary in the following situations

On answering machine at home / Cell Phone

On voicemail at work

With:

1. \_\_\_\_\_ Phone Number : \_\_\_\_\_

Relation: \_\_\_\_\_

2. \_\_\_\_\_ Phone Number : \_\_\_\_\_

Relation: \_\_\_\_\_

3. \_\_\_\_\_ Phone Number : \_\_\_\_\_

Relation: \_\_\_\_\_

B. \_\_\_\_\_ I do not consent to messages being left. Please speak to me directly.

\_\_\_\_\_  
Print Name

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature

# Financial Policy and Waiver

## **Insurance Deductibles/ Co-Payments/ Co-Insurance:**

In accordance with my insurance contract, I understand that deductibles, co-payments and co-insurances are due at the time of service. This contractual obligation requires that payments be made at the time of service. If I am unable to do so, I understand that my appointment may be rescheduled. All outstanding balances over 30 days old, may be subject to a 10% per annual interest rate.

## **Verification of Benefits and Non-Covered/Denied Services:**

Insurance policies may differ patient plan. Reno Tahoe Pain Associates may provide services that my insurance plan excludes. Although Reno Tahoe Pain Associates makes every attempt to notify me of my benefits, it is ultimately my responsibility to verify and understand my coverage, benefits and exclusions. All non-covered services are my responsibility and may be due at time of service, based on contracted rates

## **Change of Insurance:**

I must notify Reno Tahoe Pain Associates within 30 days of my new insurance. This ensures that all claims be re-filed as appropriate. In the even that my insurance changes and I fail to notify the office within 30 days, any outstanding balances associated with denied insurance claims will become my responsibility.

## **Private Pay:**

If I do not have insurance coverage, or a Reno Tahoe Pain Associates contracted plan, payment is required in full at time of service.

## **Collections:**

I understand that once an account is placed in a collection status, all future services must be paid in full at time of service. If my account is placed into collections, I will be responsible for all collection costs equal to 50% of my outstanding balance, but no less than \$25.

## **No-Show/ Late Cancellations:**

There is a maximum of 3 allowances for no show or late cancellation visits. If this occurs 3 times, you will be discharged from Reno Tahoe Pain Associates. You must check-in 15 minutes prior to your appointment, or it will result in a no-show and fee. We have a \$25 fee for patients who are considered no-show and do not cancel or reschedule their appointment/procedure 24 hours prior to their scheduled time.

If you are a new patient, you will not be rescheduled and your referring provide will be notified. We ask that you arrive 30 minutes prior to your new patient appointment. If you arrive after your appointment time, you will be rescheduled.

## **Returned Checks Due to Non-Sufficient Funds (NSF):**

Any returned checks due to NSF, will have a \$25 charge that must be paid prior to your next appointment, along with the funds originally guaranteed to Reno Tahoe Pain Associates. Your appointment will be rescheduled, if you do not provide payment. Unfortunately, if you have a check that is returned for NSF, Reno Tahoe Pain Associates will no longer accept checks as a form of payment form you. You must provide payment in the form of cash, or credit card.

**By signing below, I have agreed to the Financial Policy and Waiver and will adhere to the policies.**

\_\_\_\_\_  
Print Name

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature

## Urine Drug Screening Program

This notice is presented to explain the policy of Reno Tahoe Pain Associates regarding Narcotic Prescriptions and our Urine Drug Screening (UDS) program.

The possible treatments available for pain include various modalities, one of which is the use of narcotic and/ or non-narcotic prescription medications. While these medications may be extremely beneficial, as with any other treatment, there are certain risks associated with their use. Unfortunately, these risks include diversion, obtaining prescriptions for recreational use, or in order to illegally sell medication to others.

This is a major concern to us, as physicians. Additionally, this unsafe and concerning practice has reached national prominence, earning the attention of multiple government and law enforcement agencies, including the United States Drug Enforcement Agency (DEA) and State Law AB474. At Reno Tahoe Pain Associates, we take this matter very seriously.

As part of our decision to ensure proper medication utilization, we employ a urine drug screening program. This program allows us to confirm that medications are being taken as prescribed. It also allows us to ensure the absence of other harmful agents, including recreational or street drugs.

Please understand that a request to submit a sample is not an accusation. The vast majority of tests performed confirm proper medication usage. Additionally, we randomly test patients, thus eliminating any bias that we as providers, may have. However, in certain circumstances, we may obtain mandatory urine drug screenings. We appreciate your understanding and cooperation, and of course, we remain available to discuss any questions, concerns or comments you may have.

## Urine Drug Screening Patient Financial Responsibility

Regretfully, this may or may not be covered by your insurance. While a majority of insurance companies do in fact pay for this service, some do not. For this reason, we have an advanced beneficiary notice (ABN) that you will need to sign, if you are screened at our facility. This notice simply states that you understand this screen may not be covered by your insurance, and in the event that it is not, you will be financially responsible for the fees incurred. We will do our best to work with you if your insurance does not pay for this service. Please remember, it is ultimately your responsibility to be aware of your insurance benefits.

Additionally, please be aware that we may use a third-party lab for preliminary and final confirmation of the screen. This means that you may receive an Explanation of Benefits (EOB) for your insurance regarding our initial screen and another one from the third-party that confirms our results. If you have any questions regarding the billing from the third-party lab, please contact them directly.

Please remember that you may or may not receive medications from our facility and this may or may not be tested. This notification is given to prevent any confusion or misunderstanding in the future, and to ensure that all patients understand our commitment to providing the best care and service.

**By initialing below, you acknowledge our Urine Drug Screening Program, and adhere to the requirements of RTPA.**

\_\_\_\_\_ **Initials**



AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_

I authorize the use or disclosure of the above named individuals health information as described below. The following individual or organization is authorized to make the disclosure:

**Reno Tahoe Pain Associates**  
**5500 Reno Corporate Drive, Suite 300 Reno, NV 89509**  
**P: 775-384-1127**  
**F: 775-384-2478**

The type and amount of information to be used or disclosed is the ENTIRE MEDICAL CHART, including medical records, office notes, hospital records, pharmaceutical records, laboratory records, x-ray, MRI and CT reports, and any other radiological reports. I understand that the information in my health records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health issues, treatment for alcohol, drug use, pregnancy and/or family planning.

This information may be disclosed to and used by the following individual or organization:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

P: \_\_\_\_\_ F: \_\_\_\_\_

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the person or entity I authorized to release my information. I understand this revocation will not apply to information that has already been released in response to this authorization. I understand this revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall be in full force and effect until such time as the medical provider no longer maintains health insurance. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

A photocopy of this authorization shall be considered as effective and valid as original.

\_\_\_\_\_  
Signature

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Witness Signature

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# PATIENT DEMOGRAPHICS

<b>Patient Information</b>															
Last Name		First Name		Middle Name		Suffix		Social Security #							
Gender (circle) <i>M / F</i>		Date of Birth		Marital Status (circle) <i>Divorced - Married - Separated - Single - Widowed - Other</i>				Primary Care Physician							
Preferred Language (circle) <i>English - Spanish - _____</i>			Race (circle) <i>Asian - Black - White - Other: _____</i>			Ethnicity (circle) <i>Hispanic - Not Hispanic - Unknown</i>									
Mailing Address				Apt / Lot		City / State		Zipcode		Phone #s Home (     ) Mobile (     ) Work (     )					
Email Address				How did you hear about us?				Referring Physician							
<b>Responsible Party</b>						Check if same as: <input type="checkbox"/> Patient									
Last Name		First Name		Gender (circle) <i>M / F</i>		Date of Birth		What is Patient's Relationship to Responsible Party?							
Mailing Address				Apt / Lot		City / State		Zipcode		Phone #s Home (     ) Mobile (     ) Work (     )					
<b>Employer Information</b>															
Employer			Address			City / State			Zipcode						
<b>Emergency Contact</b>						Check if same as: <input type="checkbox"/> Responsible Party									
Last Name		First Name		Gender (circle) <i>M / F</i>		Date of Birth		What is Patient's Relationship to Emergency Contact?							
Mailing Address				Apt / Lot		City / State		Zipcode		Phone #s Home (     ) Mobile (     ) Work (     )					
<b>Guardian Contact</b>						Check if same as: <input type="checkbox"/> Responsible Party <input type="checkbox"/> Emergency Contact									
Last Name		First Name		Gender (circle) <i>M / F</i>		Date of Birth		What is Patient's Relationship to Guardian?							
Mailing Address				Apt / Lot		City / State		Zipcode		Phone #s Home (     ) Mobile (     ) Work (     )					
<b>Insurance Information</b>						Check If: <input type="checkbox"/> Self Pay									
Check if same as: <input type="checkbox"/> Responsible Party						Check if same as: <input type="checkbox"/> Responsible Party									
Subscriber / Member Name				Date of Birth		Subscriber / Member Name				Date of Birth					
What is Patient's Relationship to Subscriber?			Gender (circle) <i>M / F</i>			What is Patient's Relationship to Subscriber?			Gender (circle) <i>M / F</i>						
Primary Insurance Company				Begin Date		Secondary Insurance Company				Begin Date					
Insurance Mailing Address				City / State		Zipcode		Insurance Mailing Address				City / State		Zipcode	
Subscriber / Member #				Group #		Subscriber / Member #				Group #					

\_\_\_\_\_  
Patient/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Legal Guardian Print